Student Information

District Name: _____ **Dates of Service:** _____

Student Name: _____ **Student Date of Birth:** _____

Student ID: _____

Instructions

Please enter accurate information for each individually numbered session. This includes: **Session Information, Session Description, Direct Medical Services,** and **Non-Billable Services.**

Provider **must** select from the choices listed for each category.

NOTE: All fields must be filled out electronically or by hand.

Session Information and Description

Session Keys	Enter the date service was rendered.	Enter the number of hours/mins service was delivered.	*Select 1:*		*Select 1:*			*Select 1:*		
			Size		Progress			Location		
Session Number	**Date of Service (MM/DD/YYYY)**	**Duration**	**Individual**	**Group**	**Progressed**	**Maintained**	**Regressed**	**In District**	**Out of District**	**Out of District at an NJ APSSD** (NJ Approved Private School for Students with Disabilities)
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Comments Section

	Session Notes Use for Notes in regard to Session Information and Description. Include all applicable notes for each service rendered.
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Direct Medical Services and Health Evaluations

Session Number	Psychiatric Evaluation - Psychologist **(90791)**	Psychiatric Evaluation - Social Worker **(90791)**	Psychiatric Diagnostic Evaluation **(90791)**	Psychotherapy **(90832)**				TBI Counseling, Individual Family **(90847)**	Psychological Services - Sensory Integrative Techniques, Individual **(97533)**
	Psych evaluation	Social Worker Evaluation	Psych diagnostic evaluation	Cognitive	Counseling	Occupational/ Vocational Training	Psychotherapy	School Family Counseling	Sensory Intergrative Therapy
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Non-Billable Services

Session Number	Student not present	Service Provider not present	Other
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Comments Section

	Session Notes Use this section for any additional notes in regard to Direct Medical Services and Health Evaluations. Include all applicable notes for each service rendered.
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Service Provider Information

Provider Name (Printed):

Provider Name (Signature):

Date of Signature:

If providing the health related direct service "Under the Direction", the following information must be completed:

Supervisor Name:

Supervisor Signature:

Date of Signature: